

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3769

## CERTIFICATE OF DEATH

03749

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>SOMERSET</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CRISFIELD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>39 CRISFIELD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>E.W. McCREADY MEMORIAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HARRISON</u> Middle <u>CHAMBERS</u> Last <u>CHAMBERS</u>		4. DATE OF DEATH Month <u>3</u> Day <u>4</u> Year <u>19 58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-16-1890</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>TOM CHAMBERS</u>		14. MOTHER'S MAIDEN NAME <u>EMMA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-16-4495</u>	
17. INFORMANT <u>ANNA CHAMBERS</u>		Address <u>CRISFIELD, MARYLAND</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>543X TOXIC MYOCARDITIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MALNUTRITION</u> DUE TO (c) <u>SUBACUTE GASTRITIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u> <u>1 YEAR</u> <u>SEVERAL YR</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 26</u> , 19 <u>58</u> , to <u>Mar. 4</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Mar 3</u> , 19 <u>58</u> , and that death occurred at <u>6:15 A. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. N. Barr, M.D.</u>		ADDRESS (Street, city or town, state) <u>Crisfield, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>A. N. BARR, M.D.</u>		DATE SIGNED <u>3/4/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>MAR 9-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HOPWELL</u>	22d. LOCATION (City, town, or county) (State) <u>CRISFIELD MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Howard Marion Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 11 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Alfred</u>			

11 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3765

## CERTIFICATE OF DEATH

Reg. Dist. No. 03750

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN lb <b>Lifetime</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>329 Chesapeake Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>DAISY</b> Middle <b>BELL</b> Last <b>CHARNICK</b>		4. DATE OF DEATH Month <b>March</b> Day <b>11</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 23, 1881</b>
9. AGE (In years last birthday) <b>77 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Smith Island, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>John W. Marshall</b>		14. MOTHER'S MAIDEN NAME <b>Mahalia Thomas</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <b>Elsie Mae Charnick--Crisfield, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Parkinson's Disease</b> <b>350x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>March 11 58</b>		(County) (State)	
21. I certify that I attended the deceased from <b>March 8 58</b> , to <b>March 11 58</b> , that I last saw the deceased alive on <b>March 8 58</b> , and that death occurred at <b>11:00 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Main St.--Crisfield, Md.</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Sarah M. Peyton</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Sarah M. Peyton, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Mar. 14, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons--Crisfield, Md.</b>		24a. REC'D BY REGISTRAR <b>MAR 18 '58</b> 24b. REGISTRAR'S SIGNATURE <b>W. H. H. H.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND  
 DEPARTMENT OF HEALTH - BALTIMORE 10  
 1935  
 CERTIFICATE OF DEATH

DECEASED Name John A. Kennedy		SEX Male		RACE White		DATE OF BIRTH May 23, 1891		PLACE OF BIRTH United States, Md.		DECEASED Name John A. Kennedy		SEX Male		RACE White		DATE OF BIRTH May 23, 1891		PLACE OF BIRTH United States, Md.	
DECEASED Name John A. Kennedy		SEX Male		RACE White		DATE OF BIRTH May 23, 1891		PLACE OF BIRTH United States, Md.		DECEASED Name John A. Kennedy		SEX Male		RACE White		DATE OF BIRTH May 23, 1891		PLACE OF BIRTH United States, Md.	

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 BALTIMORE  
 DEPARTMENT OF HEALTH

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

03751

Reg. Dist. No.

3766

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sackertown Rd.</b>		d. STREET ADDRESS <b>Sackertown Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>WESLEY</b> Last <b>DIZE</b>		4. DATE OF DEATH Month <b>March</b> Day <b>13</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 20, 1904</b>
9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chef</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>	
11. BIRTHPLACE (State or foreign country) <b>Crisfield, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>John Wesley Dize</b>		14. MOTHER'S MAIDEN NAME <b>Mattie Cook</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-05-6335</b>	
17. INFORMANT <b>Theo Dize--Sackertown Rd.--Crisfield, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CORONARY INSUFFICIENCY &amp; ANGINA</b> DUE TO <b>HYPERTENSION</b> (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>FEW MINUTES</b> <b>4 YEARS</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>481X POST-14 FLUENZA STATE</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>MARCH 23, 1954</b> to <b>MARCH 13, 1958</b> , that I last saw the deceased alive on <b>MARCH 11, 1958</b> , and that death occurred at <b>6.00 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>P. N. Barr, M.D.</b>		ADDRESS (Street, city or town, state) <b>Crisfield, Md.</b> DATE SIGNED <b>4/15/58</b>	
PHYSICIAN'S NAME (Type) <b>A. N. Barr, M. D.</b>		<b>Main St.--Crisfield, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 15, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Asbury Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons--Crisfield, Md.</b>		24a. REC'D BY REGISTRAR <b>MAR 20 '58</b> 24b. REGISTRAR'S SIGNATURE <b>W. H. Leach</b>	

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CERTIFICATE OF DEATH

THE DEATH OF

WAS REPORTED BY

DECEASED

REPORTER

CITY

RESIDENCE

LOCATION

AGE

SEX

RACE

Y.O.B.

DATE OF BIRTH

DATE

TIME

U.S.A.

STATE

COUNTY

CITY

DECEASED

DECEASED

DECEASED

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## 3770 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 2 Film 0226 3-24-58 et

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marion Station</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>MarumSCO</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Keith James Gayle</u>		4. DATE OF DEATH Month <u>March</u> Day <u>14</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <u>Bachelor</u>	8. DATE OF BIRTH <u>Dec. 13, 1958</u> 3 Mo. 5 D.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>McCreedy Hospital</u> <u>Cristfield</u>	
13. FATHER'S NAME <u>Russell Gayle</u>		14. MOTHER'S MAIDEN NAME <u>Shirley F. Horsey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Shirley F. Horsey</u>		Address <u>Marion Sta. Rt. 1 #108</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cold</u> (a), stating the underlying cause last. (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>—</u> Minute <u>—</u> Month <u>—</u> Day <u>—</u> Year <u>1958</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>W. H. Coulbourn, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-17-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>EBENEZER</u>	22d. LOCATION (City, town, or county) (State) <u>MarumSCO, Som. Co. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles A. Ward - Marion Sta., MD.</u>		24a. REC'D BY REGISTRAR <u>—</u>	24b. REGISTRAR'S SIGNATURE <u>—</u>

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FOR STATE  
HEALTH DEPT



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03753

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> <b>3771</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PRINCESS ANNE</b> c. LENGTH OF STAY IN lb <b>LIFE</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PRINCESS ANNE,</b> d. STREET ADDRESS <b>7</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN T. HAYMAN</b> First Middle Last		4. DATE OF DEATH <b>3</b> Month <b>2</b> Day <b>19</b> Year <b>58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/14/1905</b>
9. AGE (In years last birthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Peace Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U S A.</b>		13. FATHER'S NAME <b>MATHOIS HAYMAN</b>	
14. MOTHER'S MAIDEN NAME <b>HENRIETTA WHITE</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>JEROME HAYMAN - PRINCESS ANNE, MARYLAND</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Acute coronary Heart Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>acute</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>R.H. Johnson</b> EXAMINER'S NAME (Type) <b>R.H. Johnson</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>March 4-1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/6/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>JOHN WESLEY</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCESS ANNE, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WILLIAM H. JAMES JR. PRINCESS ANNE, MD</b> ADDRESS		24a. REC'D BY REGISTRAR <b>DATE</b> 24b. REGISTRAR'S SIGNATURE <b>Wesley</b>	

MAR 11 '58

STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
PLACE OF DEATH		CITY		COUNTY		STATE		HOURS	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH	
MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		POST-MORTEM	
FAMILY HISTORY		PREVIOUS ILLNESS		HABITS		DIET		OTHER	
SIGNATURE OF EXAMINER		DATE		PLACE		CITY		COUNTY	

*Great coronary heart disease*

*acute*

RECEIVED  
JAN 14 - 1928  
BUREAU V. S.

*R.H. Johnson*  
*officer*

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03754

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

3772

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Somerset</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westover</u> c. LENGTH OF STAY IN 1b <u>18 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Somerset</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westover</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>ETTA</u> First <u>MAY</u> Middle <u>HOLLAND</u> Last <b>4. DATE OF DEATH</b> <u>MAR 29</u> 19 <u>58</u> 5. SEX <u>Fem</u> 6. COLOR OR RACE <u>col</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>DEC 12 1895</u> 62 yrs. 9. AGE (in years last birthday) <u>62</u> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u> 11. BIRTHPLACE (State or foreign country) <u>Westover, Somerset</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>WILLIAM BENSON</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>MARTHA MILES - Weston</u> <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____ <b>16. SOCIAL SECURITY NO.</b> <u>218-20-4702</u> <b>17. INFORMANT</b> <u>Elwood Holland - Westover, Md.</u> Address _____			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Heart Disease</u> <u>420.1</u> DUE TO (b) <u>Hypertension - Chronic Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>5-10 Min</u> <u>5 years</u>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____ <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u> <b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> (County) (State) _____			
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/></b> <b>ACTUAL SIGNATURE</b> <u>R. H. Johnson</u> M.D. <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>EXAMINER'S NAME (Type)</b> <u>R. H. Johnson</u> <b>DATE SIGNED</b> <u>Mar 31-1958</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BUR</u> <b>22b. DATE THEREOF</b> <u>Apr 2-1958</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Westover</u> <b>22d. LOCATION (City, town, or county)</b> (State) <u>Westover, Somerset, MD.</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Charles H. Ward</u> ADDRESS <u>Marion Sta, Md</u> <b>24a. REC'D BY REGISTRAR</b> <u>APR 7 '58</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>W. DeLoach</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



Acute Coronary Heart Disease  
Hypertension - Chronic Myocarditis 2 years.  
2-10-1938

BUREAU V. 3

APR 7 1938

RECEIVED  
APR 31 - 1938

R. H. Johnson  
R. H. Johnson

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03755

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westover</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS <b>Westover</b>	
3. NAME OF DECEASED (Type or print) First <b>NOLAN</b> Middle <b>V.</b> Last <b>ROSS</b>		4. DATE OF DEATH Month <b>March</b> Day <b>4</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 26, 1886</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Blacksmith</b>	
11. BIRTHPLACE (State or foreign country) <b>Somerset County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Theodore Ross</b>		14. MOTHER'S MAIDEN NAME <b>Mary Virginia Adams</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Ruth Chelton-1002 Upton Rd.-Harundale-</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> 241 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Myocarditis</b> DUE TO (c) <b>Bronchial Asthma</b>		INTERVAL BETWEEN ONSET AND DEATH <b>0</b> <b>1-5 years</b> <b>8 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Robert H. Johnson</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED	
EXAMINER'S NAME (Type) <b>Robert H. Johnson</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <b>March 7-1958</b>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Mar. 8, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Episcopal Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Princess Anne, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Bradshaw &amp; Sons—Crisfield, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 10 '58</b>	24b. REGISTRAR'S SIGNATURE <b>W. H. Leach</b>



FOR STATE  
HEALTH DEPT.



Donor's Name: [illegible]  
Address: [illegible]  
City: [illegible]  
State: [illegible]

Sex: Male  
Race: White  
Age: 71  
Date of Birth: April 26, 1886  
Place of Birth: Somerset County, Md.  
U.S.A.  
Theodore Rose  
Mary Virginia Adams

Mr. Ruth Chelton-1000 Upper Rd.-Baltimore-  
Md. 21206

*Chronic Myocarditis*  
*Ischemic heart disease*  
*Coronary atherosclerosis*

BUREAU V. B.

RECEIVED  
MAR 10 1958

*Robert H. Johnson*

Robert H. Johnson

Butler  
Mar. 1, 1958  
Somerset County  
Baltimore & Long-Chesfield, Md.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03756

3774

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Crisfield</b> c. LENGTH OF STAY IN 1b <b>Life</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Somerset</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield, Maryland</b> d. STREET ADDRESS <b>R.F.D.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Columbus</b> Middle <b>Warren</b> Last <b>Sterling</b>		4. DATE OF DEATH Month <b>March</b> Day <b>24</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 29, 1888</b>
9. AGE (In years and birth day) <b>70</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, if retired)	11. BIRTHPLACE (State or foreign country)
<b>Seafood &amp; Produce Dealer</b>		<b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>John Arron Sterling</b>	
14. MOTHER'S MAIDEN NAME <b>Cornelia Wilson</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	
16. SOCIAL SECURITY NO. <b>218-14-2595</b>		17. INFORMANT Address <b>Mrs. Royce Stering, Crisfield, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Arterio Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Disease</b> (c) <b>Coronary Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, if item 19)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
22. ACTUAL SIGNATURE <b>Wm H Coulbourn</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>3/26/58</b>	
23. EXAMINER'S NAME (Type) <b>James L. Hennen</b>		24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Crisfield, Md.</b>	
25a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		25b. DATE THEREOF <b>3/27/58</b>	
25c. NAME OF CEMETERY OR CREMATORY <b>Asbury Cemetery</b>		25d. LOCATION (City, town, or county) (State) <b>Crisfield, Maryland</b>	
26a. REC'D BY REGISTRAR DATE <b>MAR 28 '58</b>		26b. REGISTRAR'S SIGNATURE <b>Wm H Coulbourn</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 22 1958

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

03757

3767

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>39 Crisfield</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mariners Section</b>		d. STREET ADDRESS <b>Mariners Section</b>	
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>VEASEY</b> Last <b>STERLING</b>		4. DATE OF DEATH Month <b>March</b> Day <b>3</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 13, 1873</b>
9. AGE (In years last birthday) <b>84</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>waterman and farmer</b>	
11. BIRTHPLACE (State or foreign country) <b>Crisfield, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>James B. Sterling</b>		14. MOTHER'S MAIDEN NAME <b>Sally Moore</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Luther T. Sterling--Crisfield, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Toxic Myocarditis</b> DUE TO <b>450.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Inanition</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>6 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchial Asthma, Benign Prostatic Hypertrophy &amp; Obstruction</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 29, 1957</b> , to <b>Mar 3, 1958</b> , that I last saw the deceased alive on <b>March 1, 1958</b> , and that death occurred at <b>7:30 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. N. Barr, M.D.</b> M.D.		ADDRESS (Street, city or town, state) <b>Crisfield, Md.</b> DATE SIGNED <b>3/4/58</b>	
PHYSICIAN'S NAME (Type) <b>A. N. Barr, M. D.</b>		<b>Main St.--Crisfield, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Mar. 5, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons--Crisfield, Md.</b>		24a. REC'D BY REGISTRAR <b>MAR 7 '58</b> DATE 24b. REGISTRAR'S SIGNATURE <b>W. E. Beach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

County	Chesapeake
City	Chesapeake
Age	20
Sex	Male
Marital Status	Single
Occupation	Student
Date of Death	March 13, 1958
Place of Death	Chesapeake, Md.
Physician	James B. Sterling
Signature	James B. Sterling

BUREAU Y. 5

MAR 7 1958

RECEIVED

RECEIVED  
MAR 5 1958  
Baltimore, Md.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3775

## CERTIFICATE OF DEATH

03758

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>				c. LENGTH OF STAY IN 1b <b>69 YRS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EDW. W. MCGREADY MEMORIAL HOSP.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JAMES L STERLING</b>				4. DATE OF DEATH <b>MARCH 22 19 58</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-26-1888</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INSPECTOR</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>TIDEWATER FISH</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>JAMES STERLING</b>				14. MOTHER'S MAIDEN NAME <b>MARY BATTS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>MARY S. ENNIS</b> Address <b>CRISFIELD, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Wrenia acute S &amp; I Heart</b> <b>592x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Int. nephritic Chanc. nephritic</b> DUE TO (c) <b>Post uric Bimcleris</b>							INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Eulops Crystale General Arterio Fibrosis</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>no</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 3, 1958</b> , to <b>March 22, 1958</b> , that I last saw the deceased alive on <b>March 20, 1958</b> , and that death occurred at <b>6:40 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>George C. Coulbourn</b> M.D.				DATE SIGNED <b>March 26 1958</b>			
PHYSICIAN'S NAME (Type) <b>GEORGE C. COULBOURN, M.D.</b>				MARION STATION, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 24, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rehobeth Baptist Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rehobeth, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons--Crisfield, Md.</b>				24a. REC'D BY REGISTRAR <b>MAR 26 58</b>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
 CERTIFICATE OF DEATH

RECEIVED  
 MAR 26 1953  
 BUREAU V. 8

WILLIAM BOND  
 JAMES BOND  
 JAMES BOND

1. NAME OF DECEASED: [illegible]  
 2. SEX: [illegible]  
 3. AGE: [illegible]  
 4. DATE OF BIRTH: [illegible]  
 5. PLACE OF BIRTH: [illegible]  
 6. OCCUPATION: [illegible]  
 7. CAUSE OF DEATH: [illegible]  
 8. PLACE OF DEATH: [illegible]  
 9. DATE OF DEATH: [illegible]  
 10. SIGNATURE OF PHYSICIAN: [illegible]  
 11. SIGNATURE OF REGISTRAR: [illegible]

12. NAME OF HOSPITAL: [illegible]  
 13. NAME OF PHYSICIAN: [illegible]  
 14. NAME OF REGISTRAR: [illegible]  
 15. NAME OF WITNESS: [illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3776

## CERTIFICATE OF DEATH

03759

Reg. Dist. No.

261

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marion Station</b>		c. LENGTH OF STAY IN 1b <b>42 yrs.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marion Station</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>H.</b> Last <b>Ward</b>		4. DATE OF DEATH Month <b>3</b> Day <b>11</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 16, 1915</b>
9. AGE (In years last birthday) <b>42</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seaford Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Marion Station</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Ward</b>		14. MOTHER'S MAIDEN NAME <b>Minnie Cottman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Minnie Ward</b> address <b>Marion Sta., Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute Dil. of heart</b> 710.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Dicoid Lupus Erythem Atosus, face + hands</b> DUE TO (c) <b>Scleroderma shoulders, chest arms + flanks</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 or 8 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>028.1 Syphilis - late + latent -</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 11, 1958</b> , to <b>March 11, 1958</b> , that I last saw the deceased alive on <b>March 11, 1958</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>George C. Coubourn</b> M.D.		ADDRESS (Street, city or town, state) <b>Marion Sta. Md.</b> DATE SIGNED <b>3- -58</b>	
PHYSICIAN'S NAME (Type) <b>George C. Coubourn MD.</b>		<b>MARION STATION - MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/16/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Family Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Marion Sta., Md. Som. Co.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles H. Ward</b>		ADDRESS <b>Marion Sta., Md.</b>	
24b. REC'D BY REGISTRAR <b>Alfred Leach</b>		24c. REGISTRAR'S SIGNATURE <b>Alfred Leach</b>	
DATE <b>MAR 18 '58</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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10.15.12 10.15.12 10.15.12

William H. West 3 28

14 APR 1974

26499 100-101

March 21, 1900

Minnie Collins

Alvin W. Ward

297

BUREAU V. S.

MAR 18 1958

RECEIVED

Charles H. Ward  
March 2/10/28

Marion Station  
Family Cemetery

122

3777

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>		c. LENGTH OF STAY IN 1b <b>62 YRS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EDW. W. MCCREADY MEMO. HOSP.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JEFF</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>26</b> Year <b>19 58</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-2-1896</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>OYSTER SHUCKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SEAFOOD</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JAMES WHITE</b>		14. MOTHER'S MAIDEN NAME <b>CAROLINE POTTER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MILKY WHITE</b>		Address <b>331 CHESAPEAKE AVE. CRISFIELD, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>480X</b> DUE TO <b>Typhoid Myocarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Bronchopneumonia</b> DUE TO <b>Influenza</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute Insufficiency &amp; Chronic Passive Congestion</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>2 weeks</b> <b>6 weeks</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Feb 10, 1958</b> , to <b>Mar 26, 1958</b> , that I last saw the deceased alive on <b>March 26, 1958</b> , and that death occurred at <b>11:10 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>CRISFIELD, MARYLAND 3/26/58</b>			
ACTUAL SIGNATURE <b>A. N. BARR, M.D.</b>		M.D. <b>CRISFIELD, MARYLAND</b>	
PHYSICIAN'S NAME (Type) <b>DR. A. N. BARR</b>		<b>CRISFIELD, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Mar. 30, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Wesley Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>R.F.D. Marion Station, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons--Crisfield, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 31 '58</b>	24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED

MAR 31 1958

BUREAU V. E.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 10

3768

CERTIFICATE OF DEATH

Reg. Dist. No. 03761

1. PLACE OF DEATH o. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>	
c. LENGTH OF STAY IN 1b <b>50 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>113 S. 4th St.</b>		d. STREET ADDRESS <b>113 S. 4th St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES HARRISON WHITTINGTON</b>		4. DATE OF DEATH Month Day Year <b>March 3 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 9, 1892</b>
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seafood Industry</b>	
11. BIRTHPLACE (State or foreign country) <b>Marion Station, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Oliver Whittington</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Cottingham</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Miss Thelma Whittington-Crisfield, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Generalized Arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>few months</b> <b>3 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 19 <b>53</b> to <b>March 3</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Feb 3</b> , 19 <b>58</b> , and that death occurred at <b>3:30 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. N. Barr, M.D.</b>		ADDRESS (Street, city or town, state) <b>Crisfield, Md.</b>	
DATE SIGNED <b>3/4/58</b>			
PHYSICIAN'S NAME (Type) <b>A. N. Barr, M. D.</b>		Main St.--Crisfield, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Mar. 6, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Wesley Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Marion Station, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons—Crisfield, Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <b>MAR 7 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Overhach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15. *Journal of the American Medical Association*, 1990; 263: 1001-1005.

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DOI: 10.1002/for

RECEIVED

MAR 7 1958

Wiley Online Library

5201-2-2006

100-443887-1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G227 3-28-58 et

## CERTIFICATE OF DEATH

3778

Reg. Dist. No.

03762  
261

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marion Station</u> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Somerset</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marion Station</u> d. STREET ADDRESS <u>/</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>B.</u> Last <u>Whittington</u>		4. DATE OF DEATH Month <u>March</u> Day <u>12</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 15, 1886</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR: Months <u>7</u> Days <u>11</u> Hours <u>11</u> Min. <u>11</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seafar Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Marion Sta., Md. Som. Co.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Joseph Whittington</u>		14. MOTHER'S MAIDEN NAME <u>Elnora (Unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>220-09-182</u>		17. INFORMANT Address <u>Mrs. Emma Whittington - Marion Sta., Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Condition</u> DUE TO (b) <u>Chronic Myocarditis - Co. Out Nephritis</u> DUE TO (c) <u>several years</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>8:30 AM</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Marion Sta., Md.</u>	
20f. (City or town) <u>Marion Sta.</u>		(County) <u>Som. Co.</u>		(State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>Mar. 12, 1958</u> , to <u>Mar. 12, 1958</u> , that I last saw the deceased alive on <u>Mar. 12, 1958</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>George C. Coulbourn</u>		M.D. <u>Marion Sta. Md.</u>		DATE SIGNED <u>3-13-58</u>	
PHYSICIAN'S NAME (Type) <u>George C. Coulbourn</u>		M.D. <u>Marion Station - Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/16/58</u>		22c. NAME OF CEMETERY <u>MT. PEER</u>	
22d. LOCATION (City, town, or county) <u>Marion Sta., Som. Co.</u>		(State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ward</u>		ADDRESS <u>Marion Sta., Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 18 58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. H. Ward</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 18 1958

BUREAU V. 2

Charles H. Hays - Marion Sts, Md  
Bureau 3/16 for Mr. Hays

Marion Sts

Joseph Whittington  
330-C-101 Mrs. Emma Whittington - Marion Sts., Md.  
Elinor S. (Unknown)  
Marion Sts, Wm. Sts. 5/12/54  
Marion Sts 12  
Aug. 10, 1952  
William B. Whittington  
March 12 52

Marion Station

Marion Station

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10